UROGYNECOLOGY CENTER
NORTHERN VIRGINIA

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NEW PATIENT HEALTH HISTORY

Name: _____ Date of Birth: _____ Age: _____
Today's Date: _____ Primary Care Doctor: _____ Primary Care Phone: _____
Referring Doctor: _____ Referring Doctor Phone: _____
Preferred Pharmacy Name: _____City: _____ Phone: _____

CHIEF COMPLAINT
What is the main reason you are seeing the doctor today?

_____
_____

Please fill in below or attach list, if available.

ALLERGIES: (Please list all medication allergies, including shellfish, etc.)
If no allergies, check here: ☐
_____
_____

MEDICATIONS: (Please list all medicines including over-the-counter, supplements and vitamins.)
If no medications, check here: ☐
_____
_____

MEDICAL PROBLEMS: (Please check all that apply.)

☐ Heart Disease	☐ Hepatitis	☐ Plasma Transfusion
☐ Diabetes	☐ Renal Disease	☐ Glaucoma
☐ High Cholesterol	☐ Thyroid Disorders	☐ Mitral Valve Prolapse
☐ High Blood Pressure	☐ Chronic Urinary Tract Infections	☐ Migraine Headaches
☐ Low Blood Pressure	☐ Arthritis	☐ Infectious Mono
☐ Stroke	☐ Anemia	☐ HIV
☐ COPD / Emphysema	☐ Epilepsy	☐ Eczema
☐ Asthma	☐ Blood Transfusion	☐ Hemorrhoids
☐ Bronchitis	☐ Glaucoma	☐ Tuberculosis
☐ Hx. Of Blood Clot/DVT	☐ Other:	

If no medical problems, check here: ☐

SURGERIES:

☐ Tonsillectomy	☐ Wisdom Tooth	☐ Appendectomy	☐ D&C
☐ Gallbladder Surgery	☐ Tubal Ligation	☐ C-Section	☐ Hysterectomy
☐ Shoulder Surgery	☐ Vasectomy	☐ Knee Surgery	☐ Laparoscopy
☐ Hernia Repair	☐ Colonoscopy	☐ Other:	

If no prior surgeries, check here: ☐

Weight: _____ Height: _____
When was your last EKG? _____ Where? _____
When was your last chest x-ray? _____Where? _____

Name: _____ Date of Birth: _____

SOCIAL HISTORY:

Occupation: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Tobacco Use: ☐ Never Smoked ☐ Former Smoker ☐ Current Every Day Smoker ☐ Current Some Day Smoker ☐ Smoker Current Status Unknown ☐ Current Smokeless Tobacco User ☐ Unknown if Ever Smoked ☐ Exposure Secondhand Smoke

Do you drink alcohol? ☐ No ☐ Yes ☐ Prior History of abuse Do you use street drugs? ☐ No ☐ Yes

What is your caffeine use: ☐ No ☐ 1-2 cups/day ☐ More than 3 cups/day

FAMILY HISTORY:

	Father	Mother	Brother	Sister	PGF*	PGM*	MGF*	MGM*
Prostate Cancer								
Renal Cancer								
Bladder Cancer								
Testicular Cancer								
Heart Attack								
Heart Disease								
Stroke								
High Blood Pressure								
High Cholesterol								
Diabetes								
Kidney Disease								
Urinary Stones								
Cystic Fibrosis								
Tuberculosis								
Other Cancer Type: _____								
Other Family Hx.:_____								

If there is no family history of any of the above, check here: ☐ If family history is not available, unknown or unobtainable, check here: ☐ * PGF – Paternal grandfather (father's father) PGM – Paternal grandmother (father's mother) MGF – Maternal grandfather (mother's father) MGM – Maternal grandmother (mother's mother)

MEDICAL HISTORY:

Do you now or have you had any problems related to the following symptoms: (If not checked, it will mean that you do not have that symptom or condition.)

General
☐ Fatigue
☐ Night Sweats
☐ Chills
☐ Weight Gain
☐ Weight Loss

Skin
☐ Ulcers
☐ Rash
☐ Itching
☐ Lesions

Head
☐ Chronic Headaches
☐ Head Injury / Trauma

Eyes
☐ Vision Loss
☐ Double Vision
☐ Visual Disturbances

Ears, Nose & Throat
☐ Ear Ringing
☐ Nosebleeds
☐ Hoarseness
☐ Decreased Hearing
☐ Bleeding from Gums

Respiratory
☐ Chronic Cough
☐ Wheezing
☐ Difficulty Breathing

Heart
☐ Chest Pain
☐ Murmur (req. antibiotics)
☐ Palpitations

Gastrointestinal
☐ Constipation
☐ Diarrhea
☐ Nausea
☐ Vomiting
☐ Rectal Bleeding

Urinary
☐ Blood in Urine
☐ Incontinence
☐ Kidney Stones
☐ Frequency
☐ Urgency
☐ Venereal Disease / STDs

Muscular-Skeletal
☐ Back Pain
☐ Joint Pain
☐ Joint Swelling
☐ Muscle Weakness
☐ Muscular Pain or Tenderness

Neurological
☐ Dizziness
☐ Seizures
☐ Tremor

Psychiatric
☐ Anxiety
☐ Depression
☐ Mood Changes

Endocrine
☐ Appetite Changes
☐ Sexual Dysfunction

Hematology
☐ Easy Bruising
☐ Prolonged Bleeding

If none of the above symptoms, check here: ☐

Name: _____ Date of Birth: _____